

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **1597**

Registration District No. **19**

Primary Registration District No. **5025**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

- (a) County **Atchison**  
(b) City or town **Rock Port**  
(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME **JAMES EDWARD KIME**

3. (b) If veteran, \_\_\_\_\_  
name war \_\_\_\_\_  
3. (c) Social Security No. **✓**

4. Sex **MALE**  
5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **8** **2** **1921**  
(Month) (Day) (Year)

8. AGE: Years **19** Months **5** Days **14**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **K. M. Kime**  
13. Birthplace **Westham, Mo.** (City, town, or county) (State or foreign country)  
14. Maiden name **Linn Kime**  
15. Birthplace **Rock Port, Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature \_\_\_\_\_  
(b) Address **Rock Port, Mo.**

17. (a) **Burial** (b) Date thereof **1-18-1941**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crematory**

18. (a) Signature of funeral director **Frank Berthelmann**  
(b) Address **Rock Port, Mo.**

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo.** (b) County **Atchison**  
(c) City or town **Rock Port**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **16**  
year **1941** hour **10** minute **20 A.** A. M.

21. I hereby certify that I attended the deceased from **Jan 14**  
\_\_\_\_\_, 1941, to **Jan 16**, 1941;  
that I last saw him alive on **Jan 16**, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
**Rheumatic heart disease**  
**with congestive failure**  
Due to **rheumatic heart**  
**disease**

Due to \_\_\_\_\_

Other conditions **Chronic progressive**  
(Include pregnancy within 3 months of death)  
**myocarditis**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy **none**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **none**

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **James Kime** (M. D. or other) \_\_\_\_\_

Address **Rock Port, Mo.** Date signed **Jan 16, 1941**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No.

15977

Registration District No. 19

Primary Registration District No. 5028

Registrar's No.

1. PLACE OF DEATH:

(a) County Atchison  
(b) City or town Clay, Mo.  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether  
In this community. years, months or days)

3. (a) PRINT FULL NAME James Edward Kime

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
19 5 14 hr. min.

9. Birthplace Atchison Co. (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

12. Name K m Kime

13. Birthplace mo (City, town, or county) (State or foreign country)

14. Maiden name Fern Kime

15. Birthplace mo (City, town, or county) (State or foreign country)

16. (a) Informant Wm Kime

(b) Address Rockport

17. (a) Burial (b) Date thereof 1-18-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Grady Bartholomew

(b) Address Rockport

19. (a) 1-18-41 (b) Mary H. Chamberlain  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Atchison

(c) City or town Rockport  
(If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A. years.

3. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 16  
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19  
that I last saw him alive on 19  
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease with congestive failure

Due to 121

Other conditions Chro. Progressive nephritis  
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury

23. Signature Emmett B. Lettler (M. D. or other)

Address Rockport Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-1597